STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G050	A. BUILDING _____ B. WING _____	C 07/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINIER SCHOOL PAT A	RYAN ROAD BUCKLEY, WA 98321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS This report is the result of a Complaint Investigation (2826622/2827971) conducted at Rainier School PAT A on June 24, 2013. Facility deficiencies were found and cited as noted below. The investigation was conducted by: [redacted] R.N., B.S.N. The investigation team is from: ICF/IID Survey and Certification Program Residential Care Services Division Aging and Long-Term Support Administration Department of Social and Health Services P O Box 45600 Olympia, Washington 98504-5600 Telephone: 360-725-2419 Fax: 360-725-2642	W 000		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interviews and record reviews the facility failed to follow facility policies with regard to Medication Administration and Documentation and SOP (Standard Operating Procedure) 6.01	W 149		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Supt. 8/28/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 149	Continued From page 1 Client Safety and Protection. This failure placed 16 of 16 residents (Resident #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, & 16) at risk of medication errors, potential missing residents, and potential harm. Findings include: All observations, interviews, and record reviews were completed on 06/24/13 unless otherwise specified. Medication Cart in back hallway: Review of the Medication Administration and Documentation policy revealed that the " medication carts will be located on the living unit in a fixed area. This area will be in a quiet area (as much as possible). " Based on the facility ' s 5-day Investigation Staff B arrived on the house at approximately 6:55 am, went straight to the medication room to clean, supply, and set up her cart for the medication pass. Review of the 5 day Facility Investigation dated 06/09/13 Staff F stated that Staff B ' s medication cart was blocking Resident #1 & 2 ' s doorway and Staff F had to push it out of the way in order to access the door to open Resident #1 & 2 ' s door. Intershift Report: On 06/24/13 Staff A was interviewed and was asked about the normal practice for intershift report. Staff A referred to the facility ' s SOP (Standard Operating Procedure) 6.01 Client Safety & Protection. The facility policy states that staff are to " Verify the presence of every resident assigned to a living unit at least twice daily. " Such counts must take place at 10:15 pm and 6:15 am and be completed prior to the end of the shift that is going off duty. Facility 5-day Investigation report on 06/09/13 revealed that Staff D (night) & E (day) signed the intershift report but did not complete the walk	W 149	**W149 – Staff Treatment of Clients** Based on the facility's Medication Administration Procedure Staff B (LPN) was following the procedure as it applies to clients with enteral feedings. (page 6 under Medication Administration and Documentation) Clients with enteral feedings are allowed to receive their medications in a private area (bedroom, etc.) secondary to dignity and privacy issues. Records from the five day investigation showed that Staff B had just completed enteral medications for client #4 and was returning to the medication room when staff B found the wash cloth in the doorjamb and placed the cart in front of the door. Staff B (LPN involved) was in-serviced on 6/19/13 on administration of medications in the assigned area. Completed 6/19/13 Rainier School will train all nurses on SOP 6.01, Client Safety and Protection related to blocking of client doorways, access and egress. Completion 9/30/13 RN4 to complete random review of medication cart placement during medication pass monitoring for blocking of doorways (access and egress) for 5 medication passes per quarter ensuring solutions are sustained. Start date 9/30/13 And Ongoing **Person Responsible** RN4 **Monitor** PAT A DDA2/ Director of Nursing	

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W 149	Continued From page 2 through as required by the policy. Staff E arrived to work late (6:20 am) signed the intershift report and went directly to work getting ready for breakfast. Staff D did not ask another staff member to complete the intershift rounds with her before she left; therefore Residents were not verified as being on the unit from approximately 5:00 am to 8:00 am.	W 149	All Naches AC staff will be in-serviced on SOP 6.01. Rainier School Twice Daily Count form will be completed per requirement of SOP 6.01 Completed 6/30/13 All PAT A AC staff will be trained on SOP 6.01. Rainier School Twice Daily Resident Count form will be completed per requirement of SOP 6.01. Completion 9/30/13 AC Managers will review and initial twice daily count sheets per their house and observe a minimum of one inter-shift per month. Start Date 9/30/13 and Ongoing PAT A Management will monitor AC managers schedule to ensure solutions are sustained on a monthly basis. Start Date 9/30/13 and Ongoing **Person Responsible** **PAT A DDA1** **Monitor** **PAT A DDA2**	
W 270	483.450(a)(1)(iii) CONDUCT TOWARD CLIENT These policies and procedures must specify client conduct to be allowed or not allowed. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure 2 of 2 residents (Resident #1 & 2) were able to exit their bedroom through their doorway when the door to their room was found to have a washcloth/rag lodged in the doorframe. This failure jeopardized the residents ' safety and created a potential for harm or injury. Findings include: All observations, interviews and record reviews occurred on 06/24/13 unless otherwise indicated. Review of the Facility Incident Report revealed that on 06/09/13 at 08:00 am a washcloth/rag was found lodged between the door and the door frame of room occupied by Resident #1 & 2. Per review of investigation the door was pulled shut with the washcloth/rag in the door causing door to be difficult to open by the staff. Review of Resident #2 ' s record noted that he has a history of pica (mouthing and/or ingesting inedible substances) and seizures that are stable at this time on medications, although a pad was noted to be on the floor beside the bed to help	W 270		

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W 270	Continued From page 3 prevent injuries. Observation of Resident #1 & 2 ' s door way noted that there were 2 open areas in the door frame where the door latches. Staff A stated that the washcloth/rag was stuffed into the 2 open areas and the door had been closed. Staff A stated that he did not personally see the towel/rag in place but Staff F told him he had observed the washcloth before it was removed. Staff A is unsure of the reason the washcloth/rag was placed in the doorframe. The door to Resident #1 & 2 ' s did not squeak and did not close on its own without someone physically pulling the door shut. When asked Staff A stated that Resident #1 & 2 are independent with their mobility however he is unsure that they would have been able to leave their room without the assistance of staff due to the difficulty of opening the door with the washcloth/rag in it. During investigation Resident #1 was in his room sleeping. Resident #2 was observed sitting in the living room of the house and then got up and ambulated to the bathroom and then back to the chair without staff assist. Attempted to interview Resident #2 but did not answer questions appropriately and became anxious with investigator. Rainier School SOP (Standard Operating Procedure) 3.11 Dignity states that " Rainier School employees are prohibited from: initiating a situation, in which an individual is purposefully ignored, slighted, scorned, or disregarded for the purpose of controlling him/her. Extinction may only be used in a properly approved, formal program. In the DDA Policy 5.15 - Use of Restrictive Procedures shows that prohibited procedures are " locking a client (resident) alone in a room. " Review of facility documents and employee	W 270	**W270 Conduct Toward Client** All Naches AC staff will be in-serviced on SOP 3.11 client's right to dignity as well as DDA Policy 5.15, the use of restrictive procedures. Completed 6/30/13 All AC staff on PAT A will be in-serviced on SOP 3.11 client's right to dignity as well as DDA Policy 5.15, the use of restrictive procedures. Completion 9/30/13 PAT A AC managers will complete a minimum of one observation per shift per month to ensure client dignity and to ensure unauthorized use of restrictive procedures is not occurring. Start Date 9/30/13 and Ongoing PAT A Management will monitor AC Managers schedule to ensure solutions are sustained on a monthly basis. Start Date 9/30/13 and Ongoing **Person Responsible** **PAT A DDA1** **Monitor** **PAT A DDA2**	

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W 270	Continued From page 4 statements revealed there is no determination as to who or when the washcloth/rag was placed in the door or how it got there. At the time that the washcloth/rag was found both residents were still in bed sleeping.	W 270		